



# DISABILITIES LAW PROGRAM

## COMMUNITY LEGAL AID SOCIETY, INC.

100 W. 10th Street, Suite 801  
Wilmington, Delaware 19801  
(302) 575-0660 TTY (302) 575-0696 Fax (302) 575-0840  
www.declasi.org

### MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Regulatory Initiatives

Date: November 21, 2016

Consistent with the requests of the SCPD and GACEC, I am providing analyses of three (3) regulatory initiatives published in the November issue of the Register of Regulations. Given time constraints, the analyses should be considered preliminary and non-exhaustive. DHSS also published in the Register a solicitation of comments on the 197-page DDDS revised HCBS (Lifespan) Waiver [20 DE Reg. 378 (11/1/16)]. Comments are due by December 19 and I plan to share my analysis with the Councils before the end of November.

#### 1. DOE Prop. Public, Private & Nonpublic School Definitions Reg. [20 DE Reg. 338 (11/1/16)]

In July, 2016 the Department of Education published an earlier version of this proposed regulation. The SCPD and GACEC submitted comments with two recommendations: 1) the definition of charter school should include a reference to operation in an approved physical plant to prevent a “cyber” school from qualifying as a charter school; and 2) the definition of school district was ambiguous since it recited that a Vo-Tech district “may” meet the definition.

The Department is now issuing a revised proposed regulation which addresses both concerns.

First, it revises the definition of “public school” (which is incorporated into the definition of “charter school”) to include a reference to having a “physical plant”.

Second, it has separate definitions of “reorganized school district” and “school district” with a caveat that a “school district” is included in the definition “depending on the context in which the term is used”. This concept is reinforced by a new preamble to §2.0: “The following words and terms are applicable unless a specific regulation, statute or the context in which they are used clearly indicates otherwise”.

I did not identify any new concerns with the regulation. Since the revised initiative addresses both observations identified in the Councils’ July commentary, the Councils may wish to consider endorsement.

## 2. DMMA Prop. Medicaid Outpatient Drug Reimbursement Reg. [20 DE Reg. 342 (11/1/16)]

The Division of Medicaid & Medical Assistance proposes to amend the Medicaid State Plan in the context of reimbursement for outpatient drugs.

As background, the Division notes that CMS issued a regulation effective April 1, 2016 which directs states to reimburse outpatient drugs based on actual acquisition costs plus a dispensing fee, if applicable. At 343. The Division has been using that methodology since April 1, 2016 and the current proposal would amend the State Plan to conform to the CMS regulation and actual practice. The methodology applies in both the MCO and fee-for-service contexts. At 344. Since the State Plan amendment reflects current practice, DMMA indicates there “is no impact on the General Fund”. Id.

I have the following observations.

First, the dispensing fee standard is less “blunt” under the initiative. Instead of a blanket \$10 fee, a table is inserted which has higher dispensing rates in a few contexts (“specialty drugs-mailed”; “clotting factor”). At 346. There is also an apt “catch-all” provision “carried over” from the current version of the State Plan: “Exceptions will be made if documentation provided demonstrates that the product can only be obtained at a higher rate.” Id.

Second, the Plan amendment (p. 346) includes the following deletion:

~~Exceptions of the reimbursement of FUL and DMAC can be made if a physician certifies in their own handwriting that a specific brand is medically necessary. The medical necessity must be documented on a FDA Med Watch form based on the client experiencing an adverse reaction.~~

DMMA has traditionally implemented a system in which physicians could request approval of a non-generic drug based on medical necessity for an individual client considering factors such as efficacy and adverse reactions. The Councils may wish to request clarification that the above deletion is not intended to reflect a systemic change in that practice.

In sum, the Councils could consider a general endorsement since the revision is necessary to conform to CMS regulation and actual practice. The Councils could also consider requesting clarification concerning the above deletion.

## 3. DMMA Prop. DDDS Waiver Participant Patient Pay Regulation [20 DE Reg. 340 (11/1/16)]

Based on CMS regulations, DDDS waiver participants are subject to contributing a “patient pay” amount towards the cost of their waiver services. There are several deductions and exclusions in determining the “patient pay” contribution. See 42 C.F.R. §483.726 and DSSM §§20720, 20720.1, 20720.2, and 20720.3.

Historically, the patient pay amount has been paid to DDDS. See deleted sentence on p. 342. DMMA is proposing to change this approach as follows:

Individuals receiving Residential Habilitation funded by the DDDS waiver will submit their patient pay amount directly to the provider of Residential Habilitation.

At 342. No fiscal impact is contemplated,. Id. The proposal is intended “to be compliant with federal regulation”. Id. The citation to the federal regulation is not provided.

I have two observations.

First, many DDDS waiver participants have one provider for residential habilitation and a different provider for day programming. Under the proposal, the residential provider would be paid 100% of the patient pay amount. The attached CMS regulation (42 C.F.R. §435.726) does not literally apportion the patient pay contribution exclusively to the residential habilitation provider. It only generally refers to “home and community-based services”. DMMA may wish to assess whether 100% of the patient pay contribution is required to be paid exclusively to the residential provider. If not, the proposed approach may be inequitable for day program providers.

Second, I assume part of the rationale for the proposal is reduction of the administrative burden of DDDS accounting/allocating the patient pay funds. However, DDDS is the representative payee for the SSI/SSDI monthly benefits for several hundred DDDS clients. Therefore, reciting that “(i)ndividuals receiving Residential Habilitation...will submit their patient pay amount directly to the provider” will ostensibly still result in DDDS (as representative payee) allocating patient pay funds to providers. Moreover, if an individual defaults in payment to the provider, I assume this should affect waiver eligibility which is within the province of DDDS, not the provider. Therefore, if this change in approach is not required by federal regulation, DMMA may wish to consider retention of the current approach.

The Councils may wish to consider sharing the above observations with DMMA and DDDS.

#### Attachments

E:legis/2016/1116bils  
F:pub/bjh/legis/2016/1116bils

established under § 435.811, if the agency provides Medicaid under the medically needy coverage option.

(3) *Maintenance needs of family.* For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under § 435.811, if the agency provides Medicaid under the medically needy coverage option for a family of the same size.

(4) *Expenses not subject to third party payment.* Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

(5) *Continued SSI and SSP benefits.* The full amount of SSI and SSP benefits that the individual continues to receive under sections 1611(e)(1) (E) and (G) of the Act.

(d) *Optional deduction: Allowance for home maintenance.* For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(1) The amount is deducted for not more than a 6-month period; and

(2) A physician has certified that either of the individuals is likely to return to the home within that period.

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income—*(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received, or it may project monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses—*

(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and on medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980; 48 FR 5735, Feb. 8, 1983; 53 FR 3595, Feb. 8, 1988; 55 FR 33705, Aug. 17, 1990; 56 FR 8850, 8854, Mar. 1, 1991; 58 FR 4932, Jan. 19, 1993]

**§ 435.726 Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.**

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph

(c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under § 435.217 and are receiving home and community-based services furnished under a waiver of Medicaid requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement recipients under § 435.230; or

(iii) The amount of the medically needy income standard for one person established under §§ 435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under § 435.811 for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or co-insurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

[46 FR 48539, Oct. 1, 1981, as amended at 50 FR 10026, Mar. 13, 1985; 57 FR 29155, June 30, 1992; 58 FR 4932, Jan. 19, 1993; 59 FR 37715, July 25, 1994]

**§ 435.733 Post-eligibility treatment of income of institutionalized individuals in States using more restrictive requirements than SSI: Application of patient income to the cost of care.**

(a) *Basic rules.* (1) The agency must reduce its payment to an institution, for services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraphs (c) and (d) of this section, from the individual's total income.

(2) The individual's income must be determined in accordance with paragraph (e) of this section.

(3) Medical expenses must be determined in accordance with paragraph (f) of this section.

(b) *Applicability.* This section applies to the following individuals in medical institutions and intermediate care facilities:

(1) Individuals receiving cash assistance under AFDC who are eligible for Medicaid under § 435.110 and individuals eligible under § 435.121.

(2) Individuals who would be eligible for AFDC, SSI, or an optional State